MDR Tracking Number: M5-04-0958-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-02-03.

The IRO reviewed office visits, therapeutic exercises and therapeutic activities rendered from 08-21-03 through 09-08-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-06-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.
The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8/19/03	99213	$66.19 (1 unit)	$0.00	NO EOB	$44.15	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $44.15
8/19/03 and 9/3/03 (2 DOS)	97530	$218.88 (1 unit @ $36.48 X 6 units)	$0.00	NO EOB	$36.48	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $36.48 X 6 units = $218.88
8/19/03 and 9/3/03 (2 DOS)	97110	$204.30 (1 unit @ $34.05 X 6 units)	$0.00	NO EOB	$36.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
TOTAL		$489.37	$0.00				The requestor is entitled to reimbursement in the amount of $263.03

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 08-19-03 through 09-03-03 in this dispute.

This Findings and Decision and Order are hereby issued this 28th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 5, 2004

RE: MDR Tracking #: M5-04-0958-01
IRO Certificate #: **5242**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
According to the supplied documentation, it appears that the claimant injured her right hand at work on ___. Apparently, another employee accidentally stepped on a switch that caused a hot press to close on the claimant's hand. The claimant was treated at ___ on the date of injury. She was diagnosed with a 2nd degree burn and released. The claimant followed up with ___ on 07/01/2003 and began chiropractic therapy. Several diagnostic tests were performed on the claimant including x-rays, CT scan, a MRI and a EMG study. The claimant underwent a designated doctor exam by ___ on 11/19/2003 who felt the claimant was not at MMI. The documentation ends here.

Requested Service(s)
Please review and address the medical necessity of the outpatient services including office visits, therapeutic exercises and therapeutic activities rendered between 08/21/2003 – 09/08/2003.

Decision
I agree with the insurance company that the office visits, therapeutic activities and exercises rendered between 08/21/2003 – 09/08/2003 were not medically necessary.

Rationale/Basis for Decision
The supplied documentation reports the claimant sustaining a severe burn to her right hand. Apparently after some atrophy had occurred from lack of normal activity, the claimant began rehabilitation to return her to her pre-injury status. The claimant was being treated with conservative care within the current chiropractic/medical protocols. An FCE performed on 07/09/2003 documented the claimant's weakness in her right hand, validating the need for additional therapy. The claimant began her therapy on 07/01/2003 with ___. After 4-6 weeks of therapy, it would be reasonable to covert the claimant's therapy to a home-based program. Exercises to the claimant's hand could be strengthened by Theraband, putty and returning the claimant to normal activities. Although it may take a period of time for the claimant to return to 100% or MMI, it would not be necessary to have every exercise and activity monitored by a physician. Continued and ongoing chiropractic therapy is not considered reasonable or inline with current chiropractic/medical guidelines.